NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED BY OUR PHARMACY AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Protecting Medical Information

We at Brent's Pharmacy & Diabetes care value our relationship with you. Your health and safety is our primary concern and the very reason we are in business. Because of this concern we take very seriously our mandate to protect your personal information. Our pharmacy is required by the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") to maintain the privacy of your Protected Health Information (PHI). PHI is considered to be your medical records and other health information that identifies you. This includes any information we keep, use or disclose in any form, whether electronically, on paper or orally.

This "Notice of Privacy Practices" (Notice) has been created to help you understand our legal duties to protect your PHI and how we may use and disclose your PHI in relation to your past, present, and future physical or mental health condition or illness and it treatments you require. As required by HIPAA, we must provide this notice to you and make a good faith effort to obtain your acknowledgment that you have received it. This notice is effective as of April 14, 2011 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice or Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post any revised notice on our pharmacy website and you may receive a written copy of a revised notice by requesting orally or in writing.

Patient Rights under HIPPA regulations

You have rights pertaining to your own PHI as directed by The Health Insurance Portability and Accountability Act of 1996 (HIPAA). These rights are summarized as follows:

1. You have the right to receive this written Notice of Privacy Practices describing how we will protect your PHI your rights related to PHI. You are entitled to request this written Notice at any time. You have the right to request a restriction on the use and disclosure of your PHI. All requests for will be carefully considered, but please be aware that we may not be able to agree to your requested limitation if it hampers our ability to provide quality health care products and services to you. Your request may be superseded by federal or state law.

2. You have the right to review or receive photocopies of our records that contain your PHI. Most commonly, this will include prescriptions filled for you, your patient profile, and our billing records for your health care products and services. Copies of your records may have a minimal cost-based fee for photocopies of the records, together with any expenses for mailing, special courier, faxing, and supplies necessary to fulfilling your request for records.

3. You have the right to request changes in the content of your PHI contained in our records where you believe the content is incomplete, inaccurate, or for some other reason needs to be changed. We will do our utmost to comply with requests, but may not be able to agree to your requested change if we no longer have the records or if the requested change would cause your PHI to become inaccurate.

4. You have the right to request that we communicate with you about your PHI in a confidential manner and only to locations (such as a post office box) or by means (such as personal cellular telephone) specified by you.

5. You have the right to obtain an accounting of our disclosures of your PHI to third parties (persons other than those listed below that do not require your authorization by law). Other disclosures of your PHI that are not required to be included in the accounting are those made directly to you or your authorized family or representatives.

6. You have the right to file a complaint if you believe that we have violated your rights as described above, and to not fear retaliation or adverse action by us against you for exercising your right. You can file the complaint with us directly, or with the United States Department of Health and Human Services (HHS).

** All requests for the above information must be made in writing on a form provided to you by the Pharmacy Privacy Officer. If, for any reason, we are unable to comply with any of your requests for information as noted above, you will be notified in writing by our Pharmacy Privacy Officer.

How your Protected Medical Information may be used

We use and disclose your PHI primarily in relation to the health care products and services that we provide you, such as dispensing your prescriptions. Specifically, we will use and disclose your PHI as necessary to provide treatment to you, obtain payment for health care products and services provided to you, and other health care operations and activities required for your treatment. Under the law we are permitted to use and disclose your PHI without your authorization for these purposes.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples are when we contact your physician or other health care providers to obtain refill authorizations, ask questions about medication doses, inform them of potential drug interactions, or to determine validity of prescription orders.

- Payment means such activities as obtaining payment for services, confirming health plan coverage, and billing or collection activities. Examples are electronically billing your insurance company or health plan at the time we fill your prescriptions. Insurance companies or health plans may also contact us about services we provide to you.

- Health care operation includes business aspects of running our pharmacy, such as planning, financial analysis, and customer service. An example is when we look at records to evaluate how well our pharmacists and technicians provide service to you.

- Disclosures of your PHI to health related business partners, as defined by HIPPA, and caregivers. In providing health care products and services to you, we may find it necessary to communicate with businesses and individuals not already described above. These disclosures will be related to providing treatment to you, and to carrying out payment and health care operations as discussed above We may disclose your PHI to your direct caregivers, or appropriate others, as we believe necessary and appropriate for your health care.

- Federal and state government agencies may request your PHI for a variety of purposes, most of which are directed at monitoring health care quality and safety. For example, the United States Drug Enforcement Administration (DEA) monitors the distribution and usage of controlled substances, while the United States Food and Drug Administration (FDA) monitors adverse drug events.

- Federal and state government health care insurance programs. If you apply for and receive benefits from federal and state health care programs, such as Medicare, Medicaid or Workers Comp, your PHI may be disclosed to the agency granting these benefits.

- Matters of public health and safety. There are a number of federal and state laws that require health care providers to report to various government agencies matters related to public health.

- Law enforcement activities. At any time we are required by federal or state laws, or by court order, subpoena or other legal mandate, to disclose your PHI, we will do so as necessary. If you are incarcerated, or a ward of the state, PHI may be released to those responsible for your health care.

- Disclosures for national security and intelligence. We are legally required to disclose your PHI where necessary to national security activities and intelligence and counterintelligence activities. Any disclosure for these purposes would be made only to authorized government officials.

- Military or veteran status disclosures. We may disclose your PHI, if you are a member of any branch of the armed services, whether on active or reserve status as required by the U.S. Military or requested by VHA. Any disclosure for these purposes would be made only to authorized government officials.

- We may also use your PHI without your authorization to provide you with refill reminders; information about alternatives to medications or services you receive through our pharmacy; or notices of health screenings, special events, or other wellness activities we may conduct.

Uses and Disclosures Not Contained in this Notice

Your written authorization will be obtained before the use or disclosure to any party not listed in this Notice. You have the right to refuse to authorize the use and disclosure, or if you grant the authorization, to revoke the authorization at any time. If such authorization is requested, we will provide you with a form that describes the proposed use and disclosure and your rights related to the requested authorization.

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby authorize Brent's Pharmacy & Diabetes Care to use and/or disclose the protected health information described below to _____.
[Name of Individual]

2. Authorization for Release of Information. Covering the period of health care from: _____(date) to _____(date) **(must indicate a future stop date or event)**

a. □ I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

b. □ I hereby **authorize the release of my complete health record with the exception of the following information**:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ Other (please specify): _____

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. This authorization shall be in force and effect until _____, at which time this authorization expires.
[Date or Event]

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative Relationship to Patient

HIPAA Privacy Restricted Access Request Form

Request to Limit Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby request Brent's Pharmacy & Diabetes Care to disallow use or disclosure of any protected health information described below to _____.
   [Name of Individual or Third Party]

2. Covering the period of health care from:
   (Dates): _____ to _____ **(must indicate a future stop date or event)**

   a. □ I hereby **restrict access to my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

   OR

   b. □ I hereby **restrict access to any part of my health record containing the following information**:

   □ Mental health records

   □ Communicable diseases (including HIV and AIDS)

   □ Alcohol/drug abuse treatment

   □ Other (please specify): _____

4. This restriction shall be in force and effect until _____, at which time this limitation expires.
   [Date or Event]

5. I understand that I have the right to request this limitation on access to my PHI. The pharmacy is not required to accept this request. If the request is denied, the pharmacy will provide reasons for denial in writing.

_____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative Relationship to Patient

HIPAA Medical Information Correction Request Form

Request to Amend PHI or Pharmacy Prescription Records
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby request Brent's Pharmacy & Diabetes Care to make amendments to my PHI for the following reason(s):

2. I will provide pertinent medical documentation to support the request for changes to my PHI from the following sources: (Name and address of provider or institution)

_____

_____

_____

_____

3. I understand the pharmacy may not be able to agree to my requested change if they no longer have the records or if the requested change would cause my PHI to become inaccurate. If the Pharmacy is unable to agree to the requested change, I will be notified in writing.

_____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative Relationship to Patient